PRINTED: 12/01/2011 FORM APPROVED

If continuation sheet 1 of 1

DIVISION	of Health Care Faci	liities						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONS		TRUCTION	(X3) DATE SURVEY COMPLETED	
		TN3101		B. WING _				C 01/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZII						CODE	12/0	7112011
BRIDGE AT MONTEAGLE (THE) 26 SECOND STREET MONTEAGLE, TN 37356								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO SS-REFERENCED TO THE APP DEFICIENCY)	ON SHOULD BE COMPLETE DATE DATE	
N 000 Initial Comments N 000								
Complaint investigation #28573, #28727, #28814, and #28973 were completed on December 1, 2011, at The Bridge at Monteagle. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.								
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Division of Health Care Facilities ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE						TITLE		(X6) DATE

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STATE FORM